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Strategies for Addressing the Impact of Secondary Trauma on Mental Health Professionals

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CERTIFICATE OF APPROVAL

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Strategies for Addressing the Impact of Secondary Trauma on Mental Health Professionals

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Abstract

Providing effective counseling interventions means creating a therapeutic alliance through active listening. Clinicians who treat trauma survivors are frequently exposed to graphic details of the traumatic events, and in a sense absorb, this information disclosed. This secondhand exposure to traumatic events can impact clinician's personal and professional functioning. This paper aims and discussing the various encounters a counselor may experience when working with trauma survivors; as well as, various strategies to help improve health and wellness within the work environment, education, and personally.

Keywords: secondary trauma, prevalence of secondary trauma, preventative measures

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Introduction

Counselors are dedicated to providing services to vulnerable populations; including those who have been abused, neglected, chronically mentally ill, and the elderly (Newell & MacNeil, 2010). Effective counseling practices involve creating a strong working relationship, which includes knowing about the client's life and the events that have created the current state of turmoil and imbalance. Active listening, a vital component of building the therapeutic relationship, involves listening to, and to a degree absorbing, the information disclosed. This includes all the pain, trauma, and suffering that may be disclosed. Active listening to traumatic stories may have an emotional effect that compromises professional functioning and diminishes quality of life (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011). The chronic, daily exposure to clients and their distress may becoming emotionally demanding on counselors and result in the experience of secondary traumatic stress. The purpose of this paper is to provide an overview of secondary trauma and its potential impact on mental health professionals; as well as, strategies for reducing secondary trauma.

The emotional and psychological risks associated with being a provider of direct therapeutic services to client's who've experienced trauma and professional self-care in response to these risks have been overlooked in practices, training, and education (Newell & MacNeil, 2010). Within the last two decades, an increase of literature and research have acknowledged these risks and the possibility of it creating an occupational hazard. "Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma" (National Child Traumatic Stress Network, Secondary Traumatic Stress

Committee, 2011, p. 2). In essence, any professional that works directly with traumatized children is at a significant risk of experiencing secondary traumatic stress.

Review of Literature

Mental health counselors provide treatment to victims of trauma frequently encounter, "vivid descriptions of traumatic events, unsettling accounts of human cruelty and abuse, and direct witnessing of strong emotional expressions from their clients" (Robinson-Keilig, 2014, p. 1478). These types of experiences are often considered to be a common risk when working with traumatized populations. Kadambi and Truscoutt (2004) found that among 221 mental health professionals surveyed, 69.6% reported moderate to profound amounts of exposure to traumatic material. As a result of exposure to other's traumatic events, therapists may be at risk for developing their own trauma related symptoms; such as, changes in personal and professional functioning.

These types of symptoms and impairment to functioning experienced by counselors can be defined in a multitude of ways. Most commonly known is burnout, which is characterized by "emotional exhaustion, depersonalization and a reduced feeling of personal accomplishment" (Maslach, 1976). This condition can be experienced from any mental health practitioner, not just those who directly work in trauma related fields. Whereas, vicarious trauma is experienced by those who specifically work with individuals who have experienced trauma and refers to a "disturbances in the professional's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy" (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011, p. 2). Lastly, secondary traumatic stress, also known as compassion fatigue, refers to the manifestation of post-traumatic stress disorder (PTSD) symptoms cause by

at least one indirect exposure to traumatic experiences. Despite similarities in definitions, there is a distinction among the conditions.

Burnout

Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job, and is characterized by meeting the three criteria of exhaustion, cynicism, and inefficacy (Maslach, Schaufeli, & Leiter, 2001). Exhaustion is a central component to burnout and is often the most recognized and reported symptom. Exhaustion represents the stress dimension of burnout, but it fails to encompass the relationship between practitioners and their work. Individuals who experience burnout also report feelings of depersonalization, distancing themselves from their clients and considering them to be more impersonal. Distancing is a self-preservation reflex to exhaustion, and enhances feelings of cynicism and disparagement. Working under chronic exhaustion or cynicism is likely to affect feelings of success and effectiveness. It's comprehensible why someone would struggle to feel a sense of accomplishment when they are feeling exhausted or indifferent about helping others. Research has shown that exhaustion and cynicism often develop from an unmanageable workload and social conflict; whereas, feelings of inefficacy occur from lack of resources.

Vicarious Trauma

As previously stated, vicarious trauma results in a cognitive shift in beliefs and thinking after directly working with individuals who have experienced trauma (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011). This cognitive shift may include changes in perceived safety, trust, and control (Newell & MacNeil, 2010). Despite conflicting research, common factors have been identified regarding what may predispose therapists to vicarious trauma: exposure and chronic work with traumatized clients, clinician's

capacity for emotional empathy, and a history personal trauma (Devilly, Wright, & Varker, 2009). Vicarious trauma and secondary traumatic stress have similar components, which may make it difficult to define and categorize these conditions. The key difference is the emphasis vicarious trauma places on the cognitive change that results from chronic direct practice with traumatized individuals; whereas, secondary traumatic stress focuses more on the outward behavioral symptoms (Newell & MacNeil, 2010).

Post-Traumatic Stress Disorder

To further understand secondary traumatic stress it is important to understand how its symptoms mimic that of post-traumatic stress disorder (PTSD). Individuals who experience secondary stress may find themselves re-experiencing their own traumatic events or notice an increase stress response related the indirect exposure to traumatic material. Furthermore, they may experience "changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence" (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011, p. 1-2). If a counselor is experiencing a decline in emotional and/or cognitive functioning due to secondary trauma, it will obviously have an impact on client care. This impact may lead a clinician to work with other types of clients or leave the counseling field altogether.

Secondary Traumatic Stress

Secondary traumatic stress results from engaging in an empathetic relationship with an individual suffering from a traumatic experience and being exposed to the intense or horrific experiences of that particular person's trauma (Newell & MacNeil, 2010). The symptoms of secondary traumatic stress are parallel to those of PTSD with the exception that with secondary traumatic stress, the traumatic event is not directly experienced by the affected individual;

instead the stressor is the exposure to knowledge about a traumatizing event experienced by the client. Symptoms of secondary traumatic stress may include intrusive thoughts, traumatic memories or nightmares, insomnia, chronic irritability, outburst, fatigue, difficulty concentrating, hypervigilant of reminders of the client trauma, and avoidance of clients and client situations.

Prevalence of Secondary Traumatic Stress

The overall threat and impact of secondary trauma has been a major topic of research throughout the years, and it has resulted in conflicting findings. Kadambi and Truscott (2004) found that the majority of counseling participants in their study did not appear to be experiencing traumatic stress symptoms or burnout after serving clients who have experienced sexual violence, despite the fact that they perceived their work as potentially traumatizing. In fact, only 5% of participants in this study showed elevated levels of traumatic stress as measured by the Traumatic Stress Institute Brief Scale (TSI) and Impact of Event Scale (IES). These findings support other studies that have found mental health professionals are not suffering significant emotional or psychological concerns, and in fact are coping well with the demands of their work. Controversy, other studies have reported moderate to high levels of secondary trauma symptoms. Way et al. (2004) reported high levels of trauma symptoms in their sample of clinicians that treated either sexual abuse survivors or sexual offenders, with the mean in the moderate range and approximately 50% of the same reporting levels in the clinical range on the IES. Several factors may contribute to the range of secondary traumatic stress experiences across studies; such as, differences in test measurements, differences in subjective and objective levels of distress, and environmental characteristics (Elwood, et al., 2011).

Trauma Focused Clinicians

Many researchers have claimed that clinicians working exclusively with traumatized clients are at a higher risk for experiencing distress, including secondary trauma, in comparison to other mental health professionals (Elwood, et al., 2011). However there has been a lack of research that has assessed this allegation. Kadambi and Truscott (2004) compared clinicians who primarily treated either survivors of sexual violence, clients with cancer, or general practice clients. The authors utilized secondary trauma theories to predict that the clinicians working with sexual assault survivors would report the highest level of secondary trauma symptoms. However, no significant differences were found between groups regarding secondary trauma on any measurement scales, including cognitive shifts due to vicarious trauma, PTSD symptoms, or indications of burnout. Alternatively, a separate study reported that clinicians who treated sexually abuse clients endorsed greater disruption in other's safety, trust, and esteem than clinicians to treated cancer patients (Cunningham, 2003). Additionally, a study by Birck (2002) compared endorsement of symptoms of clinicians, administrators, and interprets working a treatment center for torture survivors. Findings revealed that clinicians endorsed higher levels of burnout than the other groups and higher levels of compassion fatigue than the interpreters.

However, the groups did not differ on level of trauma related beliefs. This study offered a unique opportunity to examine individuals that are presumably exposed to similar descriptions of traumatic experiences by comparing the clinician and interpreter reports. Therefore, differences that do arise suggest there may be factors related to the therapeutic relationship that affects an individual differently than disclosure of traumatic details alone. While some finding support the notion that trauma-focused clinicians experience an increase in distress; overall, findings utilizing mental health comparison groups suggest no differences in increased risk of experience

distress or secondary trauma between trauma-focused and general clinicians (Elwood, et al., 2011).

Exposure to Trauma-Related Therapy

Similarly to the claim that trauma-focused clinicians are uniquely at risk, theorists hypothesize that the level of exposure to traumatic material is correlated to the experience of secondary trauma symptoms (Elwood, et al., 2011). If true, then research should support a link between secondary trauma and variables related to the degree of trauma exposure experienced by the clinician. However, conceptualizing the construct of trauma exposure has been difficult to measure. For instance, one therapist may conduct a two hour per week of intensive, trauma-focused therapy with a single client; whereas, another therapist may spend twenty hours per week working with trauma survivors that primarily focus on non-trauma related issues. The various frequencies and intensities of exposure make it difficult to quantify the amount of trauma exposure. In an attempt to capture this concept, researchers consider the hours spent working with clients, percentage of trauma survivors in the caseload, and years working with trauma clients.

The percentage of trauma clients in a clinician's caseload is often used as a measure of secondary trauma exposure. While some studies have failed to find a relation between the percentage of trauma clients and trauma related symptoms, others have found some significant results to support this association (Elwood, et al., 2011). Similarly, examinations of the relationship between the number of hours per week spent working with trauma clients and secondary trauma symptoms have generated ambivalent results. Boberg and Regehr (2006) reported a significant correlation between hours per week and trauma related symptoms, but not cognitive distortions that are often associated with vicarious trauma. Additionally, Birk's (2002)

research did not report associations with compassion fatigue or cognitive distortions, but did find a significant correlation between hours per week and burnout. Furthermore, Creamer and Liddle (2005), found a significant relationship between the hours per week spent with trauma clients and clinicians experiencing trauma symptoms.

Research regarding time spent working in the in the trauma field have shown that a shorter length of treatment trauma clients, rather than longer, is correlated with greater symptom severity (Elwood, et al., 2011). This association has been justified by the idea that clinicians who experience the highest levels of distress in response to trauma-focused work will be more likely to leave the field than those less affected. Alternatively, other studies have failed to discover a significant relationship between the length of treatment for traumatized clients and clinician's experiencing secondary traumatic stress.

Personal Trauma History

A clinician's personal trauma history has also been considered to be a factor that puts an individual at risk for experiencing secondary traumatic stress (Elwood, et al., 2011). It's theorized that being exposed to a client's traumatic experiences, reactions, and consequent cognitive distortions can trigger a clinician's reactions to their own trauma experiences. Research regarding the correlation between the clinician's personal trauma history and experiences with secondary trauma have yielded mixed results. Several studies have reported non-significant results; whereas, others have found an association between personal history of trauma and secondary trauma history. Explanations for these conflicting results are not apparent due to the research using a variety of measures and samples. Creamer and Liddle (2005) found that while personal trauma history was not significantly associated with trauma symptoms, previous personal trauma therapy was related. Furthermore, Hargrave et al. (2006) asked participants to

indicate their perceived level of resolution regarding their personal traumatic experiences and found that those that considered their experiences to be unresolved endorsed significantly higher secondary trauma symptoms than those who considered their experiences resolved.

Preventative Measures

Despite all of the risks associated with secondary traumatic stress, there are preventative measures that can be taken to reduce the effects. Trippany , Kress, and Wilcoxon (2004), offered numerous ideas for how to support at-risk counselors; such as, "encouraging peer support groups, educating counselors on impact of client trauma on counselors, diversifying counselor caseload, encouraging counselor respite and relaxation, and encouraging counselor's sense of spirituality and wellness" (p. 26). Alternatively, Bober and Reghehr (2006) found that engaging in coping strategies that were recommended for therapists experiencing secondary traumatic stress did not immediately impact traumatic symptoms. Instead, the authors suggest that organizational structure, caseload size, hours per week serving traumatized clients, and workplace conditions all impact the occurrence and severity of secondary traumatic stress. "It is perhaps time that vicarious and secondary trauma intervention efforts shift from education to advocacy for improved and safer working conditions" (Bober & Reghehr, 2006, p. 8)

Individual Preventative Measures

It is vital for clinicians to have a professional awareness regarding preventative measures that may be used for individual and organizational use. Professional self-care is the utilization of skills and strategies by workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients (Newell & MacNeil, 2010). Self-care strategies can include, but are not limited to: setting realistic goals with regard to caseload, utilizing breaks, getting adequate rest and relaxation, and maintaining positive relationships with

friends and family. Additionally, receiving support from colleagues and supervisors may also decrease the effects of burnout and secondary trauma. Support from colleagues can include assisting with clerical work, assisting with a difficult client, consultation, and emotional support.

Consistent practice of self-care strategies and coping skills are necessary for the health and wellness of the clinician. A combination of biological and behavioral strategies; such as, maintaining physical health, balanced nutrition, adequate sleep, exercise, or recreation, can offer protection to the effects of secondary trauma. Additionally, through the use of self-expression, self-care may include artistic, culinary, or outdoor activities. Maintaining spiritual connections through religious, mindfulness, or philanthropic practices also enhances personal health and wellness. Furthermore, the use of emotional and social support from close friends and family have also been shown to help provide a defense against symptoms of secondary trauma. Lastly, for clinicians experiencing secondary traumatic stress, therapeutic support may be a beneficial option, especially for those who've personally experienced trauma.

Workplace Preventative Measures

There are several organizational characteristics that have been identified as risk factors for clinician's experiencing secondary traumatic stress; such as, systems and administrative constraints, insufficient supervision, lack of availability of client resources, and lack of support from colleagues (Newell & MacNeil, 2010). Furthermore, organizational culture has a vital impact on clinicians and the health of the work environment. Organizational culture is comprised of the assumptions, values, norms, and behaviors of its agency members. If an agency culture acknowledges the existence of secondary traumatic stress as normal reactions to client trauma may significantly impact the clinician's ability to cope. An open, non-judgmental organizational culture helps alleviate any stigma trauma workers may have about experiencing these reactions

and decreases feelings of inadequacy. One way agency supervisors and administrators can foster sensitivity and support in addressing secondary traumatic stress is by evaluating the degree to which these conditions exist within their organization. Instruments such as the Maslach Burnout Inventory, the Secondary Traumatic Stress Scale, and the Professional Quality of Life scale have been validated as measures of burnout and secondary traumatic stress. These assessments can be given during training events, agency meetings, or annual reviews. These findings can help legitimize the concerns for clinicians and create interventions to help address the problem; such as, developing a support group, increase supervision, or decrease caseload.

Educational Preventative Measures

Preventative measures associated in educational settings include teaching students the key features, warning signs, and symptoms associated with burnout and secondary traumatic stress; as well as, the importance of self-care strategies (Newell & MacNeil, 2010). This information can be integrated into course content across the program development. Helping students understand organizational risk factors prior to practicing in the field may decrease their vulnerability and increase awareness when selecting an agency to practice with. Additionally, incorporating education and skills training on self-care strategies can serve as vital practice for when students get into the field.

Conclusion

Providing therapeutic services can be a complex and difficult task, especially when working with clients who have experienced trauma. While professional burnout is a phenomenon that can occur in most any therapeutic setting, secondary traumatic stress occurs with direct practice with crisis and trauma populations (Newell & MacNeil, 2010). The overall threat and impact of secondary trauma has been a major topic of research throughout the years, and it has

resulted in conflicting findings. Several factors may contribute to the range of secondary traumatic stress experiences across studies; such as, differences in test measurements, differences in subjective and objective levels of distress, and environmental characteristics (Elwood, et al., 2011).

Despite all of the risks associated with secondary traumatic stress, there are preventative measures that can be taken to reduce the effects. These preventative measures can occur on a personal, organizational, and educational level. Professional self-care strategies can include, but are not limited to: setting realistic goals with regard to caseload, utilizing breaks, getting adequate rest and relaxation, receiving support from colleagues and supervisors (Newell & MacNeil, 2010). Personal self-care strategies that focus on maintaining physical health, creative expression, spiritual connections, and loving relationships can help reduce the effects of secondary trauma. Additionally, fostering a healthy organizational culture that is supportive can help alleviate any stigma trauma workers may have about experiencing these reactions and decreases feelings of inadequacy. Lastly, preventative measures associated in educational settings include teaching students the key features, warning signs, and symptoms associated with burnout and secondary traumatic stress; as well as, the importance of self-care strategies.

Regardless of the research having inconsistent findings regarding the significance and development of secondary traumatic stress, working with clients who have experienced significant trauma is difficult and personally impactful work. It is vital for clinician's, new and experienced, to understand the risks associated with working in this field; as well as, strategies that can help continue the effective and imperative treatment for this critical population.

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